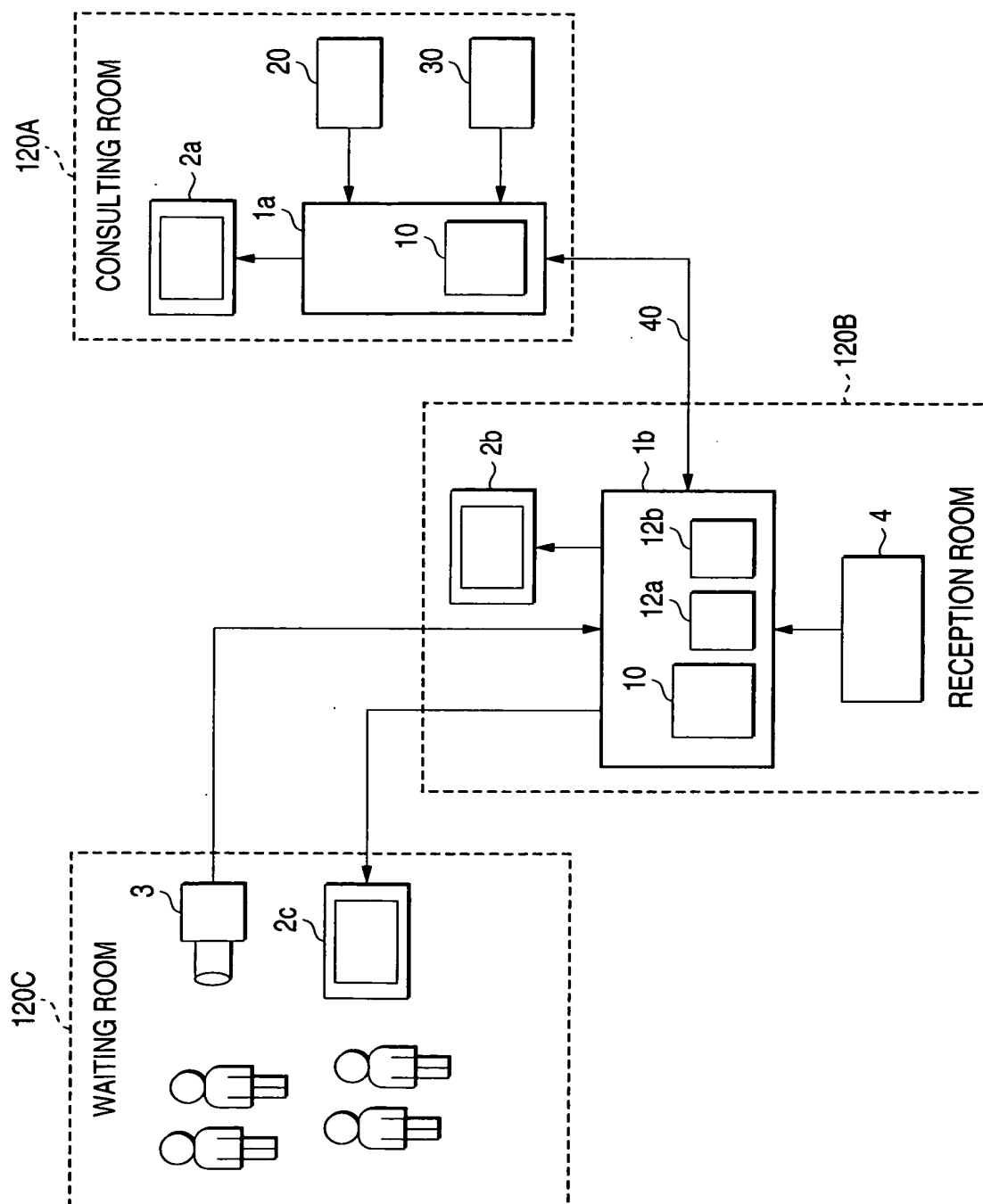


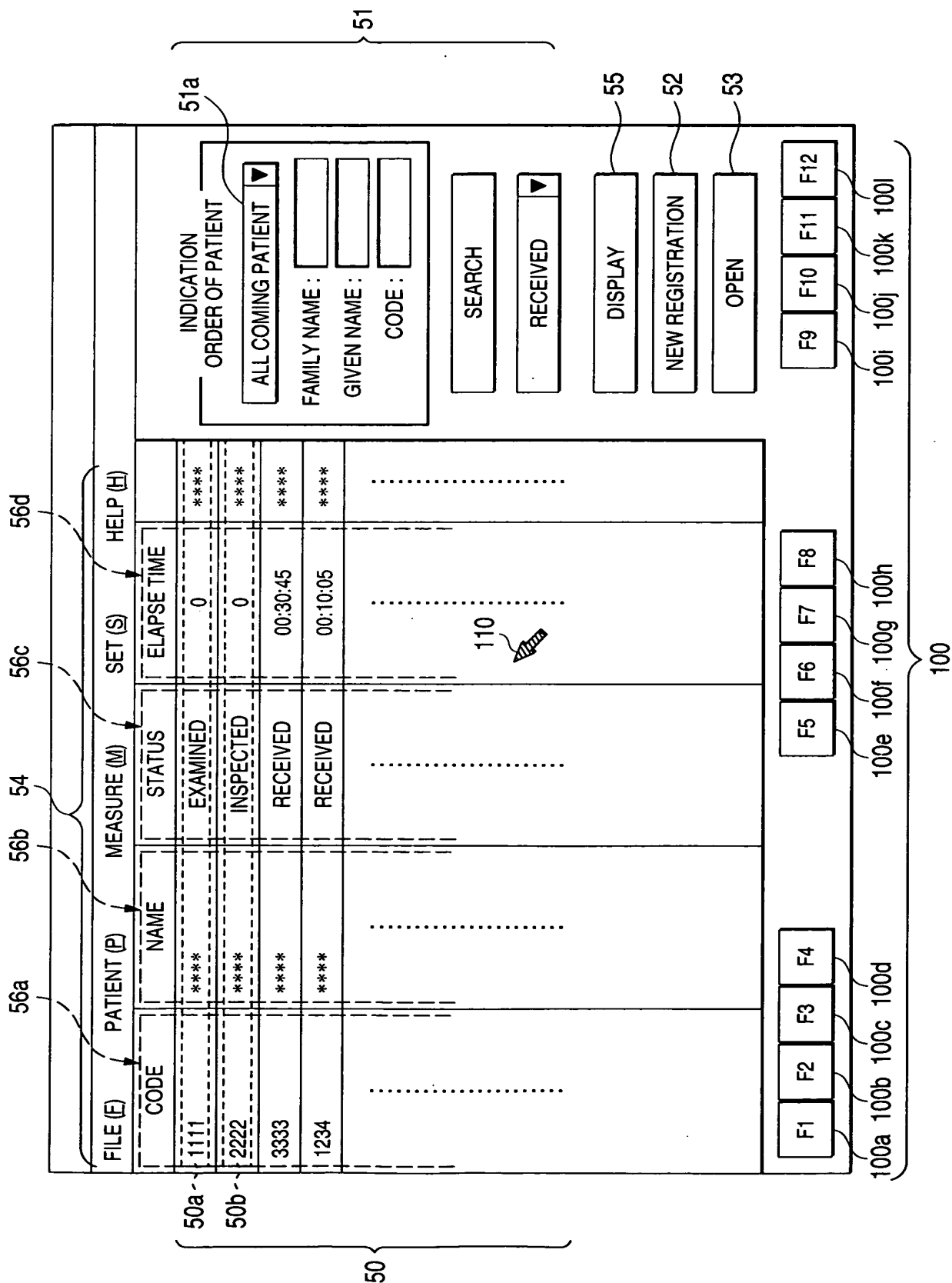
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FIG. 1



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FIG. 2



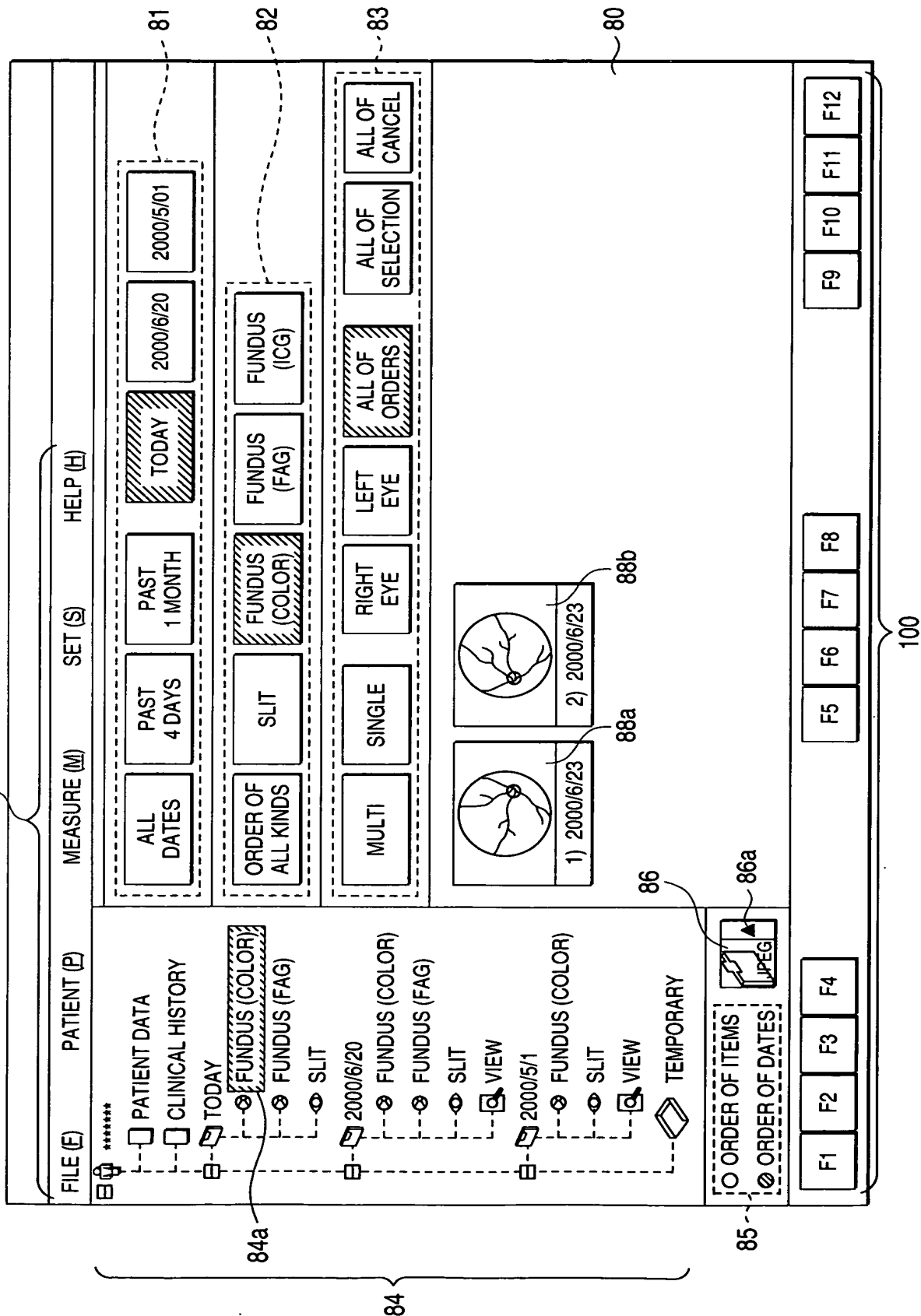
**FIG. 3**

FILE (F)	PATIENT (P)	MEASURE (M)	SET (S)	HELP (H)
<div style="display: flex; justify-content: space-between; align-items: center;"> <span>*****</span> <div style="display: flex; gap: 10px;"> <input type="button" value="OK"/> <input type="button" value="CANCEL"/> </div> </div>				
<div style="display: flex; flex-direction: column-reverse;"> <div style="margin-bottom: 5px;"><input type="checkbox"/> PATIENT DATA</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> CLINICAL HISTORY</div> <div style="margin-bottom: 5px;"><input checked="" type="checkbox"/> TODAY</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> FUNDUS (COLOR)</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> FUNDUS (FAG)</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> SLIT</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> 2000/6/20</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> FUNDUS (COLOR)</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> FUNDUS (FAG)</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> SLIT</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> VIEW</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> 2000/5/1</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> FUNDUS (COLOR)</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> SLIT</div> <div style="margin-bottom: 5px;"><input type="checkbox"/> VIEW</div> <div><input type="checkbox"/> TEMPORARY</div> </div>		<div style="display: flex; flex-direction: column-reverse;"> <div style="margin-bottom: 5px;">PHONETIC TRANSCRIPTION : (GIVEN NAME) <input type="text"/></div> <div style="margin-bottom: 5px;">PHONETIC TRANSCRIPTION : (FAMILY NAME) <input type="text"/></div> <div style="margin-bottom: 5px;">SEX : <input type="radio"/> MAN    <input type="radio"/> WOMAN</div> <div style="margin-bottom: 5px;">BIRTHDAY : <input type="text"/></div> <div style="margin-bottom: 5px;">CODE : <input type="text"/></div> <div style="margin-bottom: 5px;">FIRST MEDICAL EXAMINATION : <input type="text"/></div> <div style="margin-bottom: 5px;">ADDRESS : <input type="text"/></div> <div style="margin-bottom: 5px;">TELEPHONE NUMBER : <input type="text"/></div> <div style="margin-bottom: 5px;">DOCTOR IN CHARGE : <input type="text"/></div> <div style="margin-bottom: 5px;">E-MAIL ADDRESS : <input type="text"/></div> <div style="margin-bottom: 5px;">INSURANCE NUMBER : <input type="text"/></div> </div>		
<div style="display: flex; flex-direction: column-reverse;"> <div style="margin-bottom: 5px;"><input type="radio"/> ORDER OF ITEMS </div> <div style="margin-bottom: 5px;"><input checked="" type="radio"/> ORDER OF DATES </div> </div>		<div style="display: flex; justify-content: space-around; font-weight: bold;"> <span>F1</span><span>F2</span><span>F3</span><span>F4</span><span>F5</span><span>F6</span><span>F7</span><span>F8</span><span>F9</span><span>F10</span><span>F11</span><span>F12</span> </div>		

**FIG. 4**

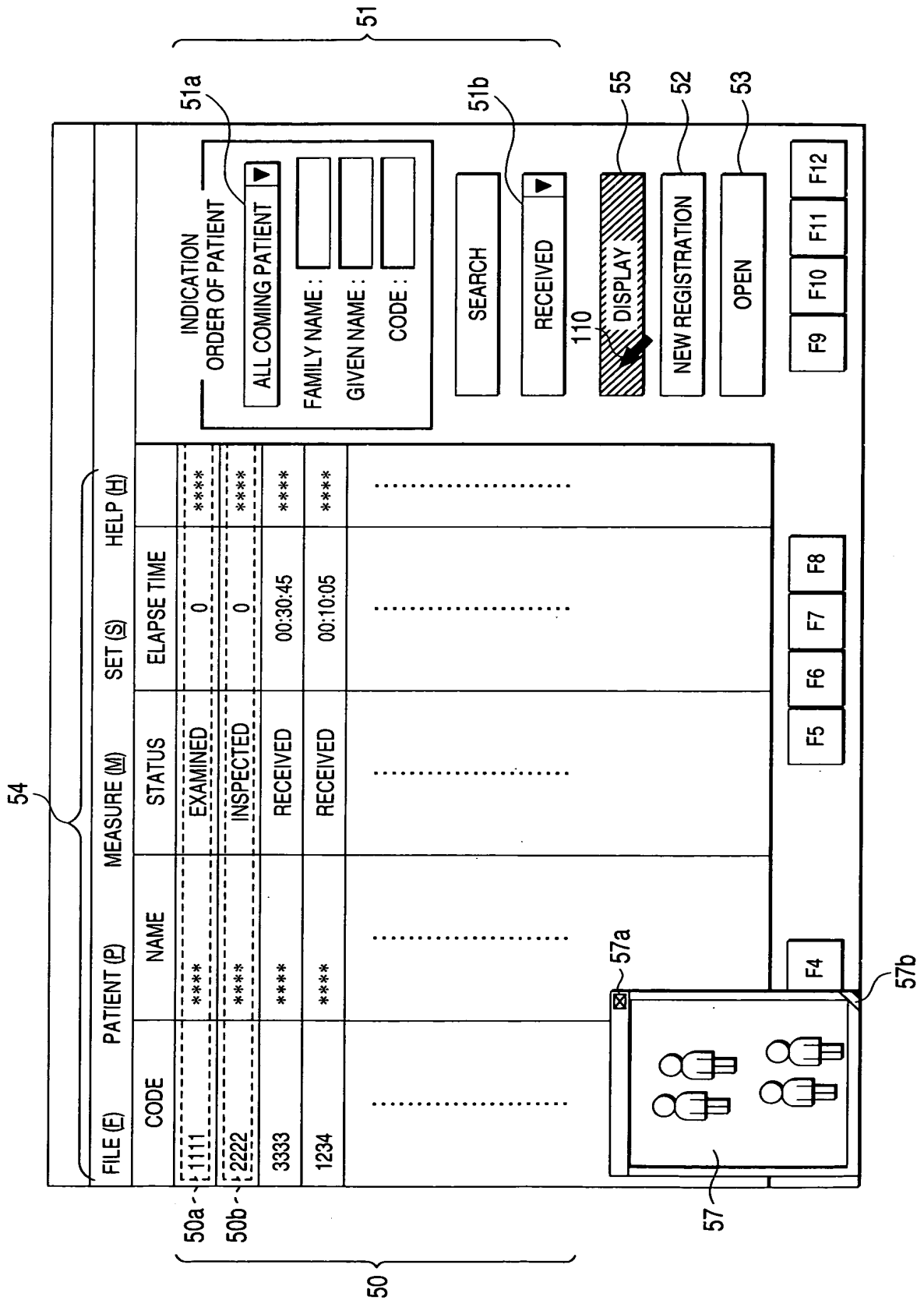
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FIG. 5



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FIG. 6



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FIG. 7

2c

NAME	STATUS	ELAPSE TIME
****	EXAMINED	0
****	INSPECTED	0
****	RECEIVED	00:30:45
****	RECEIVED	00:10:05
⋮	⋮	⋮

FIG. 8A

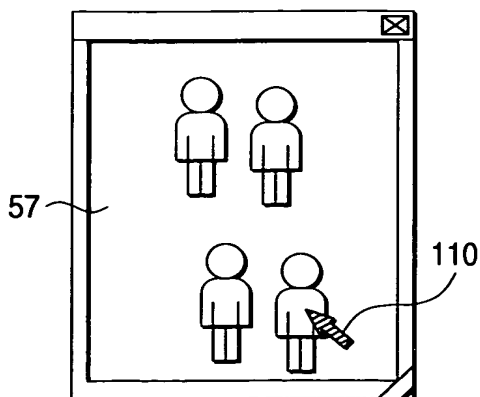


FIG. 8B

